Montana NHSC State Loan Repayment Program (LRP)
Provider Application

Primary Care	Primary Care Certified Nurse Practitioner	_____
	Certified Nurse Midwife	_____
	Primary Care Physician Assistant	_____
Mental Health	Clinical or Counseling Psychologist	_____
	Licensed Clinical Social Worker	_____
	Psychiatric Nurse Specialist	_____
	Mental Health Counselor	_____
	Licensed Professional Counselor	_____
	Marriage and Family Therapist	_____
Dental	Dentist	_____
	Dental Hygienist	_____

Provider Type – Check One

Section I: Personal Information

Name: _____
(Last) (First) (Middle Initial)

Address: _____
(Number) (Street) (Apartment/Suite Number)

_____
(City) (State/Province) (Country) (Zip Code)

Telephone: HOME: _____ WORK: _____

FAX: _____ Email: _____

Place of Birth: _____ Social Security Number: _____
(City) (State/Province) (Country)

Are you a citizen or naturalized citizen of the United States? Yes ____ No ____

Are you fluent in any language other than English? Yes ____ No ____ If Yes, please specify: _____

Section II: Education

Undergraduate Education

Name of Institution: _____ Begin Date: _____ Month/Year

Complete Address: _____ Graduation Date: _____ Month/Year

Degree(s) Obtained: _____

Health Professional Education (provide transcripts)

Name of Institution: _____ Begin Date:_____ Month/Year

Complete Address: _____ Graduation Date: _____ Month/Year

Degree(s) Obtained:_____ Name of Training Program Director:_____

Internship/Preceptorship

Name of Institution: _____ Begin Date:_____ Month/Year

Complete Address: _____ Completion Date:_____ Month/Year

Name of Supervising Professional: _____ Complete Address: _____

Section III: Professional Experience

1. Employment History: Provide name and contact information of the director or official of each site where you have practiced since completing your health professional training (Copy page as needed – provide complete site name and address):

Name: _____
Title: _____ Telephone _____
Address: _____ E-mail _____
_____
Total Hours per week: _____
Client Care: _____ Begin Date: _____
Administration: _____ End Date: _____
Other (Specify):_____

Name: _____
Title: _____ Telephone _____
Address: _____ E-mail _____
_____
Total Hours per week: _____
Client Care: _____ Begin Date: _____
Administration: _____ End Date: _____
Other (Specify):_____

Name: _____
Title: _____ Telephone _____
Address: _____ E-mail _____
_____
Total Hours per week: _____
Client Care: _____ Begin Date: _____
Administration: _____ End Date: _____
Other (Specify):_____

Section III: Professional Experience (continued)

4. List states in which you currently hold, or have held, a license to practice as a health professional

State	License Type	Dates Licensed (from to)	License Number

Note: You MUST be eligible to practice in Montana AND attach copy of license to application

5. Have you ever been subject to any disciplinary action or licensure restrictions? Yes __No __
   If Yes, by whom (Please Explain):

   _____

   _____

Section IV: Professional References Please provide names and addresses of THREE (3) professionals you have worked with or reported to:

1. Reference Name: _____

   Relationship to Applicant: _____ Telephone Number: _____

   E-mail Address: _____

2. Reference Name: _____

   Relationship to Applicant: _____ Telephone Number: _____

   E-mail Address: _____

3. Reference Name: _____

   Relationship to Applicant: _____ Telephone Number: _____

   E-mail Address: _____

Section V: Personal References Please provide names and addresses of **THREE (3)** persons, not related to you by blood or marriage, who are qualified to give information regarding your character or financial need.

1. Reference Name: _____

   Relationship to Applicant: _____ Telephone Number: _____

   E-mail Address: _____

2. Reference Name: _____

   Relationship to Applicant: _____ Telephone Number: _____

   E-mail Address: _____

Section V: Personal References (continued)

3. Reference Name: _____

   Relationship to Applicant: _____ Telephone Number: _____

   E-mail Address: _____

Section VI: Participant Requirements

1. Do you have any outstanding contractual obligation for health professional services to the Federal Government (including active military obligation, NHSC Scholarship or Loan Repayment, Nursing Education Loan Repayment, Nursing Scholarship or Faculty Loan Repayment programs) OR other program?

   Yes _____ No _____

   If Yes, Name of Federal or State Program: _____

   Complete Address: _____

   Telephone Number: _____

   Terms of obligation: _____

2. Do you have a judgment lien against property for a dept to the United States? _____ Yes _____ No

If Yes, explain _____

3. Do you have a history of failure to comply with service obligations, including

   a. Default on federal payment obligations _____ Yes _____ No

   b. Breach of prior service obligations to a federal/state or local entity? _____ Yes _____ No

Section VII: Educational Indebtedness (Attach a completed Loan Information/Verification Form for each entry)

Name of Lending Institution **Mailing Address** **Phone Number**	**Account Number**	**Balance of Account**

Section VIII: Practice Preferences

1. What date will you be available to begin practice under the Montana State NHSC LRP?
   Month/Day/Year_____

   Do you have an agreement with a designated practice site in Montana?
   Yes ____ No ____ (If yes, give location name and contact information)

   Facility Name:_____

   Facility Address:_____

   Facility CEO or Contact Name:_____

   Telephone_____

   E-mail Address_____

2. To the best of your knowledge, is this practice site a qualified National Health Service Corp practice site?

   _____ Yes _____ No

3. If you do not have an agreement, please describe preference of practice location in Montana (i.e.type of practice, distance from a hospital, size of community, preferred area in Montana, etc.) Attach page as needed.

   _____

   _____

   _____

   _____

4. Attach a one page summary of the characteristics you possess that would make you a good candidate to receive loan repayment for an underserved population practice in Montana.

Section IX: Service Obligations (NOTE: Questions 1 thru 3 are required)

If I receive loan repayment through Montana's NHSC SLRP Program I understand I must: (initial 1-3)

1. Provide primary health services to any individual seeking care _____
2. Post and honor a sliding fee scale for services _____
3. Accept Medicaid, Medicare and Healthy Montana Kids clients _____
4. How many years of service are you willing to commit? _____ 2 years _____3 years

CERTIFICATION

I certify that the information I have provided in this application is accurate and complete to the best of my knowledge and belief. I understand my responses may be investigated and any willfully false representation is sufficient cause for rejection of this application.

Signature: _____ Date _____

LOAN INFORMATION AND VERIFICATION FORM

MONTANA NATIONAL HEALTH SERVICE CORPS STATE LOAN REPAYMENT PROGRAM

South Central Montana AHEC
10 West Reeder - PO Box 872
Dillon, MT 59725
406-683-2790

The following information must be provided for each individual loan submitted as part of the provider application for MONTANA's NATIONAL HEALTH SERVICE CORPS STATE LOAN REPAYMENT PROGRAM. Print clearly and completely. Once the lending institution has completed their section of the form, please attach a current statement of account to the completed forms and submit with your application materials.

APPLICANT: Please complete one copy of this form for each loan you are including on your MT NHSC SLRP application. Please print clearly and be sure to complete all of requested information. UPON COMPLETION OF PART A, SEND THIS FORM TO YOUR LENDER TO COMPLETE THE VERIFICATION CONTAINED UNDER PART B and have them return the completed form back to you—SUBMIT BOTH COMPLETED FORMS (PART A AND PART B) WITH YOUR APPLICATION MATERIALS TO South Central AHEC at the address indicated above.

LENDING INSTITUTION: PLEASE COMPLETE PART B OF THIS FORM AND RETURN TO THE APPLICANT TO BE SUBMITTED WITH THEIR APPLICATION MATERIALS.

PART A - *(To be completed by Applicant)*

1. NAME: (Last, First, Middle) 2. BIRTHDATE: 3. SOCIAL SECURITY NUMBER:

4. COMPLETE ADDRESS: (Street, P O Box, City, State, Zip) 5. TELEPHONE NUMBER:

6. NAME OF LENDING INSTITUTION:

7. TELEPHONE NUMBER:

8. FAX NUMBER:

9. LOAN ACCOUNT NUMBER:

10. FULL ADDRESS OF LENDING INSTITUTION: (Street, P O Box, City, State, Zip)

11. LOAN INFORMATION:

Loan Account Number: _____ Original Date of Loan: _____

Original Amount of Loan: _____ Current Balance/Date: _____

12. PURPOSE OF LOAN AS INDICATED ON LOAN APPLICATION:

13. TYPE OF LOAN: ☐ Federal Family Education Loan ☐ Federal Direct Loan
☐ Federal Family Education Consolidation Loan ☐ Federal Direct Consolidation Loan
☐ Federal Perkins Loan

FOR CONSOLIDATED UNDERGRADUATE AND GRADUATE EDUCATION LOANS:
If you have consolidated your loans for undergraduate and graduate education costs, you must attach documentation outlining the individual loan numbers, loan dates and loan amounts that were consolidated into the new loan.

WARNING:
Any person, who knowingly makes a false statement or misrepresentation in this loan repayment transaction, fraudulently obtains repayment for a loan, or commits any other illegal action in connection with this transaction is subject to repaying any amount received from this program plus 8% interest. I have read this statement and understand its contents.

CERTIFICATION AND ACCOUNT AUTHORIZATION BY APPLICANT:
I hereby certify to the accuracy of the above information and apply to enter into an agreement with the Office of the Commissioner of Higher Education for repayment towards the nursing education loans I have submitted with my application hereof. These loans were incurred solely for the costs of nursing education. I hereby authorize the financial institution named in Item 5 above to release all applicable loan information to South Central AHEC as necessary.

_____ _____

SIGNATURE OF APPLICANT DATE

LOAN INFORMATION AND VERIFICATION FORM
THE MONTANA INSTITUTIONAL NURSING INCENTIVE PROGRAM

PART B - ***(To be completed by Lending Institution)***

The individual identified on the first page of this form has applied to participate in the Montana Institutional Nursing Incentive Program and states that, to the best of his/her knowledge, the loan information provided is a bona fide legally enforceable government educational loan made for the purpose of meeting the borrower's nursing educational costs. Please verify this information according to your records by completing the information below.

ACCOUNT NUMBER: _____

ORIGINAL AMOUNT OF LOAN: _____
(If this is a consolidation, please provide detail regarding the original loan amounts for all loans consolidated.)

ORIGINAL DATE OF LOAN: _____
(If this is a consolidation, please provide detail regarding the original loan dates for all loans consolidated.)

CURRENT LOAN BALANCE: _____ _____
(Balance) (Date)

LENDING INSTITUTION/LOAN SERVICER: _____
(Name)

_____
(Street Address)

_____
(City, State, Zip Code)

_____
(Telephone) (FAX)

_____
(Federal Tax ID Number)
(Required for Payment Processing)

PERSON TO CONTACT REGARDING CURRENT LOAN BALANCE INFORMATION:

_____
(Name)

_____
(Department)

_____
(Telephone)

COMMENTS:

I hereby certify to the accuracy of the loan information contained on the reverse side of this form or as provided by the above notations and comments.

_____
SIGNATURE

_____
TITLE

_____
DATE